DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8OGI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27996

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245618**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST WESTWOOD RIDGE II**
(L4) **61 THOMPSON AVENUE WEST**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/18/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Torrance, HFE NE II 01/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/23/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/21/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 01/24/2018 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245618

January 23, 2018

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Dear Ms. Schrupp:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 12, 2017 the above facility is certified for or recommended for:

37 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2018

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: Project Number S5618005

Dear Ms. Schrupp:

On November 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 2, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 18, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 12, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 2, 2017, effective December 12, 2017 and therefore remedies outlined in our letter to you dated November 29, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 23, 2018

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Reinspection Results - Project Number S5618005

Dear Ms. Schrupp:

On December 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 2, 2017, with orders received by you on December 4, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8OGI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **61 THOMPSON AVENUE WEST**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/02/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 12/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/10/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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____ 2. Facility is not Eligible
(L21)

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(L24)

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(L41)

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(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2017

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: Project Number S5618005

Dear Ms. Schrupp:

On November 2, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 12, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 2, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 2, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 30, 31, November 1, 2, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 164 SS=B	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 164		12/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure documents with resident diagnoses were confidential. This had the potential to impact 4 of 4 residents reviewed for privacy (R261, R256, R265 and R246). Findings include: On 10/30/17, at 4:39 p.m. a brief tour of the unit was completed with the nurse manager (RN)-C and signs were observed outside the rooms of R256, R246, R261 and R265. Document review	F 164	Walker Methodist Westwood Ridge II provides innovative, technically competent, effective, sensitive, individualized care and programs. We value the dignity and uniqueness of each individual and strive to maintain their autonomy and independence while providing a safe and secure environment. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 revealed each sign said, "Visitors! Please report to the nurses's station before entering room. STOP Flip to Back for Instructions. On the back of each sign were precautions related to entering each resident's room such as use of gloves, masks, gowns and hand hygiene. The back of the sign also included the diagnosis listed for the resident. Immediately following the tour, RN-C and the infection control nurse (RN)-H confirmed the staff were putting the diagnosis on the back of the sign. RN-C and RN-H explained while it would be necessary for all staff and visitors to know proper infection control precautions, it would not be necessary for all staff and visitors to know the resident's diagnosis. RN-C reported she would ensure the signs were changed to remove the diagnosis from each sign. On 10/30/17, at 4:30 p.m., R261 reported no concern related to the diagnosis on the sign outside the door. On 10/30/17 at 6:42 p.m., R256 reported no concerns related to privacy. On 11/2/17 at 9:36 a.m., R265 reported no concern related to the diagnosis on the sign outside the door. On 11/2/17 at 2:42 p.m., R246 reported no concern related to the diagnosis on the sign outside the door.	F 164	against interest of Facility, its Administrator or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within 10 days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program. The organism type for each patient was removed from the back of the isolation forms on 10/30/17. R261 discharged from facility on 11/16/17. R256 discharged from facility on 11/1/17. R265 discharged from facility on 11/9/17. R246 discharged from facility on 11/25/17. Policy regarding Transmission-Based Precautions – Isolation was reviewed and updated by Director of Nursing (DON). Transmission Based Precautions Isolation Sign Form updated to remove organism type from back of form. Licensed staff will be educated on updated Transmission Based Precautions Isolation Sign Form by DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 164	Continued From page 3	F 164	DON or designee will audit infection control signage weekly to ensure that no organism type is listed on back of form. Audits will be brought to QAA to discuss findings and need for further auditing and/or additional staff training.	
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		12/12/17

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F 309	Continued From page 4 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an initial nursing assessment accurately, which addressed the potential for bruising/bleeding for 1 of 2 residents (R264) taking anticoagulant medications. Findings include: On 10/30/17, at 2:20 p.m. R264 was observed to have a dusky discoloration on the back of the left hand. On 10/31/17, at 2:23 p.m. a dusky skin discoloration was also noted to the back of the right hand. On 10/31/17, at 2:19 p.m. R264's spouse stated the discoloration on the back of the hand was from a scratch. However, the spouse did not know how the scratch happened. There was no open area or scab on the back of R264's hands and R264 was not able to state what had caused the discolorations. Record review indicated R264 was admitted to the facility on 10/28/17, with physician orders for anticoagulants: Coumadin 2 milligrams (mg) everyday and Enoxaparin sodium solution 60 mg subcutaneously everyday.	F 309	R264 discharged from the facility on 11/19/17. Policy regarding Nursing Assessments was reviewed by DON. Licensed staff who complete admission assessments will be educated by DON or designee to ensure accurate and thorough completion of Nursing Assessment – Admission/Readmission + Care Plan is done. DON or designee will audit all new admissions weekly to ensure anticoagulant use is assessed appropriately. Audits will be brought to QAA to discuss findings and need for further auditing and/or additional staff training.	

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	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 309	Continued From page 5 A review of the Nursing Assessment-Admission/Readmission + Care Plan document dated 10/28/17, revealed R264 had bruising of the right and left inner elbows, as well as bruising of the left forearm, and the backs of the left and right hands. The nursing assessment did not identify the anticoagulant use and the initial care plan did not address anticoagulant use. On 10/31/17, at 2:52 p.m. registered nurse (RN)-E reviewed the 10/28/17, nursing assessment and verified anticoagulant use had not been checked. RN-E stated if the admitting nurse had checked the anticoagulant use then the computerized care plan would have automatically populated and addressed the potential for bleeding related to anticoagulant use. A 11/28/16 revised policy titled Nursing Assessments indicated initial and periodic comprehensive, standardized and accurate assessments of each resident's functional status was to be conducted. Assessments were to contain sufficient information related to the resident's condition to develop care planning goals based on needs, strengths, goals, life history, and preferences.	F 309		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		12/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 6 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 441		

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F 441	Continued From page 7 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, and review of residents (R256, R246), the facility failed to implement a system of surveillance to comprehensively track and identify trends in infections in real time at the facility. This had the potential to impact all 33 residents residing at the facility. Findings include: On 10/30/17, at 4:39 p.m. a brief tour of the unit was completed with the nurse manager (RN)-C. R256 and R246 had carts with personal protective equipment and signs outside the door indicating they had potentially infectious diseases. RN-C confirmed R256 and R246 had Clostridium difficile, also known as C. difficile, (a bacterium that causes diarrhea and more serious intestinal conditions such as colitis.)	F 441	R256 discharged from facility on 11/1/17. R246 discharged from facility on 11/25/17. Policy regarding Infection Control Surveillance was reviewed and updated by DON. New surveillance tracking system has been implemented to comprehensively track and identify trends in infections in real time. DON or designee will educate Infection Control Nurse on new surveillance tracking system. DON or designee will randomly audit 3 residents per week with antibiotic use against the surveillance tracking system	

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F 441	Continued From page 8 On 11/1/17 at 10:30 a.m., the director of nursing (DON) and the infection prevention nurse (RN)-H, reported infections were identified through pharmacy reports and lab reports on a monthly basis. RN-H and the director of nursing reported the interdisciplinary team discussed infections on a daily basis at clinical meetings and would initiate a tracking system if they noted a trend. When asked how a trend would be identified without a tracking system, DON and RN-H reported it would be more helpful to have a system to track infections in real time. DON and RN-H reported they did not document any information related to infections discussed during the meeting. The most recent log of infections was from September 2017. No tracking system included current infections including R256 and R246. The report entitled, Infection Summary for (illegible) of September 2017 had the following summary: facility acquired infection type, nursing unit, total # of infections, average census for month, infection rate per 1000 resident days, trends over last 4 reporting periods and action required. The trends for last 4 reporting periods, current and actions required were blank. For September there was 1 non-Foley associated UTI, one lower respiratory infection and 2 surgical wound infections. RN-H also explained how a facility map identified 5 infections for the month of September. A list of patients with antibiotics included start and stop date of antibiotic, antibiotic prescribed, directions, total dispensed and admit date. The list was printed 10/1/17. A list of organism results, printed 10/1/17, included the patient name, abnormal organism quantity, culture, and culture location. The log of laboratory results revealed 3 residents	F 441	to ensure trends in infection control are comprehensively tracked in real time. Audits will be brought to QAA to discuss findings and need for further auditing and/or additional staff training.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 441	Continued From page 9 with lab identified infections including: C difficile, which was not identified in the facility surveillance system. The antibiotic list identified 41 residents prescribed antibiotics, 36 more residents than identified in the facility surveillance system. The facility did not have a system of surveillance to comprehensively track, trend and analyze all infections in real time with data including: resident information (resident name, unit name, room number, admit date), classification (infection type, body system of infection, whether nationally recognized criteria for infection were met and whether community or facility acquired), history (symptoms, onset date, information on device used, and infection risk factors), diagnostics (if tested using radiology, lab or microbiology, collection date, type of test, specimen source, results, if organism was antibiotic resistant, antibiotic resistant organisms present) and antimicrobial starts (drug dose, route, frequency, start date, end date, total days of therapy, whether criteria were met for antimicrobial use) other information (if precautions were needed, type of precautions and infection end date) and a monthly system to identify unit monthly totals, total resident days, total number of infections by body system and number of facility and community acquired infections. The Infection Control Surveillance policy and procedure, last revised 8/2014), directed staff "The Director of Nursing/Director of Health Services will conduct ongoing surveillance (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions."	F 441		

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F 465	Continued From page 10	F 465		
F 465 SS=E	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and functional environment for 8 of 30 residents (R248, R252, R259, R14, R249, R257, R260, R246) whose rooms were observed, and found to have stained carpeting or non-cleanable objects (yarn, plastic garbage bags, and gloves) tied to the over-bed lighting pull-chains. Findings include: During observation and interview on 10/30/17, at 5:12 p.m. R248's room was observed. A light was attached to the wall over the head of R248's bed. There was a short metal pull-chain to turn the light on and off, with non-cleanable items tied to the metal pull-chain. Tied to the pull-chain was a clear plastic garbage bag, then tied to that was a red piece of string. R248 said the pull cord attached to the light broke the previous day, and after bringing the issue up with staff, was told that maintenance was not in the building on Sunday,	F 465	Policy regarding Cleaning Guidelines was reviewed by Director of Environmental Services (DES). DES or designee will complete a whole house audit to ensure all resident rooms have a long pull chain on the over-bed light with a cleanable surface. DES or designee will complete a weekly audit of rooms after a patient discharges to ensure each room has a long pull chain on the over-bed light with a cleanable surface. DES or designee will educate all housekeeping and maintenance staff on cleanable surfaces. DON or designee will educate all nursing staff on cleanable surfaces. DES or designee will complete a whole	12/12/17

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	245618	A. BUILDING _____ B. WING _____	11/02/2017

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WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 465	Continued From page 11 and would not be able to fix it until Monday. R248 said the red string and garbage bag made it so the resident could reach to turn the light on and off independently, until fixed. R248 was unsure whether staff told maintenance about the broken cord. During observation and interview on 10/30/17, at 6:36 p.m. R252's the light was attached to the wall over the head of the bed. had a short, roughly four inch, metal pull-chain to turn the light on and off. There was a cord attached to this metal pull-chain, and then a plastic garbage bag tied to the cord. R252 said the garbage bag added length which allowed R252 to tuck under the pillow so the resident could reach to turn the light on independently. R252 said the garbage bag was already tied to the cord and pull-chain upon admission. On 10/31/17, at 8:40 a.m. the light above R259's bed had a pair of disposable gloves tied to the cord that turned the light on and off. In a follow up interview that day, at 11:29 a.m. R259 said the the gloves tied to the cord had "been a life saver," and explained tucking the gloves under a pillow in bed so R259 could operate the light independently. R259 said the gloves were already tied to the cord when R259 admitted to the facility. During observation on 10/30/17, at 4:59 p.m. the light over R14's bed had plastic garbage bags tied to the light's pull-chain, and attached to the bed rail. On 10/31/17, at 9:31 a.m. plastic garbage bags were observed tied to the pull-chain connected to the light over the bed in R249's room.	F 465	house audit to identify stained carpet that needs to be replaced. A schedule will be developed to replace all permanently stained carpet by the end of the first quarter in 2018. DES or designee will complete a weekly audit of rooms after a patient discharges to ensure carpet is clean and no stains are present. If a permanent stain is identified, the carpet will be added to the replacement list. Audits will be brought to QAA to discuss findings and need for further auditing and/or additional staff training.	

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	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 465	Continued From page 12	F 465		

Additionally, the carpeting was observed to be stained with multiple dark gray/brown areas. R249 verified the carpet stains were present at the time of admission.

During observation of the room shared by R257 and R260 on 10/31/17, at 9:48 a.m. plastic garbage bags were tied to the pull-chain that attached to the light over the bed. Additionally, the carpeting had multiple light brown spots next to the bed and chair. During a follow-up interview on 11/1/17, at 2:27 p.m. R257 said the carpet stains were present at the time of admission.

During observation on 10/31/17, at 10:23 a.m. the carpet just outside the doorway of R246's room had a large pattern of dark stains.

During a tour of the environment on 11/1/17, starting at 2:19 p.m., the director of environmental services (DES) observed the black stains outside of R246's room, and confirmed that these stains were permanent, as environmental staff had cleaned as much as possible to try and remove the stain. The DES said this stain would remain until that section of carpet was replaced.

Continuing on the tour, the DES observed the soiled carpeting in the room shared by R257 and R260, and said it was possible the stains were from coffee. At this time, R257 clarified that neither R257 or R260 were coffee drinkers. The DES said that carpets were to be shampooed after each resident discharge, and explained that coffee stains should come out of the carpet during a shampoo, but might set in if not acted upon promptly. In addition to shampoo post discharge, the DES said carpets were to be cleaned twice monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 13 The DES observed garbage bags and gloves tied to the pull-chains on the lights over the heads of resident beds. The DES explained that any white cords tied to the short metal pull-chain was a cleanable cord, similar to the cords attached to bathroom call lights, and were able to be cleaned with the disinfectant soaked rags used by housekeeping. The DES confirmed that plastic garbage bags and disposable gloves should not be used to elongate the pull-cord, but that environmental services should be able to find longer metal pull-chains, or longer cleanable cords that the residents can reach, and that can be cleaned appropriately. After residents mentioned the garbage bags and disposable gloves had been there since admission, the DES wondered if it was possible that the plastic garbage bags and disposable gloves could have been in place from prior residents. Review of the Cleaning Guidelines policy, last revised 8/17/12, revealed the facility policy to "provide and maintain a safe, functional, sanitary and comfortable environment for residents, staff members and the public." Step 2, Carpeted Surfaces, established that carpets would be cleaned as needed. Step 4, Terminal Cleaning, required the unit to be stripped upon resident discharge, and cleaned and disinfected before used by the new resident.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/31/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Walker Methodist Westwood Ridge II) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/08/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/31/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Walker Methodist Westwood Ridge II is a 1-story building with no basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 34 at time of the survey.	K 000		
K 712 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 712		12/12/17

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K 712	Continued From page 2 on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/31/2017, based on documentation review and interview that the following include: The Facility does not have times for fire drill's space out to no more than 90 minutes. This deficient practice could affect the safety of all 34 of the residents, staff and visitors within the	K 712	Schedule was developed for fire drills that include one drill per shift each quarter at varying times and conditions. Director of Environmental Services or designee is responsible for correction and monitoring to prevent re-occurrence. Fire Drill Schedule will be brought to QAA to review fire drills completed and ensure drills meet varying times and conditions.	

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K 712	Continued From page 3 facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712		

Electronically delivered
November 29, 2017

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders - Project Number S5618005

Dear Ms. Schrupp:

The above facility was surveyed on October 30, 2017 through November 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	11/02/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 30, 31, November 1 and 2, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an initial nursing assessment accurately, which addressed the potential for bruising/bleeding for 1 of 2 residents (R264) taking anticoagulant medications. Findings include: On 10/30/17, at 2:20 p.m. R264 was observed to have a dusky discoloration on the back of the left hand. On 10/31/17, at 2:23 p.m. a dusky skin discoloration was also noted to the back of the	2 830	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	12/12/17

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2 830	Continued From page 3 right hand. On 10/31/17, at 2:19 p.m. R264's spouse stated the discoloration on the back of the hand was from a scratch. However, the spouse did not know how the scratch happened. There was no open area or scab on the back of R264's hands and R264 was not able to state what had caused the discolorations. Record review indicated R264 was admitted to the facility on 10/28/17, with physician orders for anticoagulants: Coumadin 2 milligrams (mg) everyday and Enoxaparin sodium solution 60 mg subcutaneously everyday. A review of the Nursing Assessment-Admission/Readmission + Care Plan document dated 10/28/17, revealed R264 had bruising of the right and left inner elbows, as well as bruising of the left forearm, and the backs of the left and right hands. The nursing assessment did not identify the anticoagulant use and the initial care plan did not address anticoagulant use. On 10/31/17, at 2:52 p.m. registered nurse (RN)-E reviewed the 10/28/17, nursing assessment and verified anticoagulant use had not been checked. RN-E stated if the admitting nurse had checked the anticoagulant use then the computerized care plan would have automatically populated and addressed the potential for bleeding related to anticoagulant use. A 11/28/16 revised policy titled Nursing Assessments indicated initial and periodic comprehensive, standardized and accurate assessments of each resident's functional status was to be conducted. Assessments were to	2 830		

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2 830	Continued From page 4 contain sufficient information related to the resident's condition to develop care planning goals based on needs, strengths, goals, life history, and preferences. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control	21390		12/12/17

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21390	Continued From page 5 practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, and review of residents (R256, R246), the facility failed to implement a system of surveillance to comprehensively track and identify trends in infections in real time at the facility. This had the potential to impact all 33 residents residing at the facility. Findings include: On 10/30/17, at 4:39 p.m. a brief tour of the unit was completed with the nurse manager (RN)-C. R256 and R246 had carts with personal protective equipment and signs outside the door indicating they had potentially infectious diseases. RN-C confirmed R256 and R246 had Clostridium difficile, also known as C. difficile, (a bacterium that causes diarrhea and more serious intestinal conditions such as colitis.) On 11/1/17 at 10:30 a.m., the director of nursing (DON) and the infection prevention nurse (RN)-H, reported infections were identified through pharmacy reports and lab reports on a monthly basis. RN-H and the director of nursing reported the interdisciplinary team discussed infections on a daily basis at clinical meetings and would	21390	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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21390	Continued From page 6 initiate a tracking system if they noted a trend. When asked how a trend would be identified without a tracking system, DON and RN-H reported it would be more helpful to have a system to track infections in real time. DON and RN-H reported they did not document any information related to infections discussed during the meeting. The most recent log of infections was from September 2017. No tracking system included current infections including R256 and R246. The report entitled, Infection Summary for (illegible) of September 2017 had the following summary: facility acquired infection type, nursing unit, total # of infections, average census for month, infection rate per 1000 resident days, trends over last 4 reporting periods and action required. The trends for last 4 reporting periods, current and actions required were blank. For September there was 1 non-Foley associated UTI, one lower respiratory infection and 2 surgical wound infections. RN-H also explained how a facility map identified 5 infections for the month of September. A list of patients with antibiotics included start and stop date of antibiotic, antibiotic prescribed, directions, total dispensed and admit date. The list was printed 10/1/17. A list of organism results, printed 10/1/17, included the patient name, abnormal organism quantity, culture, and culture location. The log of laboratory results revealed 3 residents with lab identified infections including: C difficile, which was not identified in the facility surveillance system. The antibiotic list identified 41 residents prescribed antibiotics, 36 more residents than identified in the facility surveillance system. The facility did not have a system of surveillance to comprehensively track, trend and analyze all infections in real time with data including: resident information (resident name, unit name, room	21390		

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21390	Continued From page 7 number, admit date), classification (infection type, body system of infection, whether nationally recognized criteria for infection were met and whether community or facility acquired), history (symptoms, onset date, information on device used, and infection risk factors), diagnostics (if tested using radiology, lab or microbiology, collection date, type of test, specimen source, results, if organism was antibiotic resistant, antibiotic resistant organisms present) and antimicrobial starts (drug dose, route, frequency, start date, end date, total days of therapy, whether criteria were met for antimicrobial use) other information (if precautions were needed, type of precautions and infection end date) and a monthly system to identify unit monthly totals, total resident days, total number of infections by body system and number of facility and community acquired infections. The Infection Control Surveillance policy and procedure, last revised 8/2014), directed staff "The Director of Nursing/Director of Health Services will conduct ongoing surveillance (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures related to infection control, specific to tracking and trending of infections, train staff and monitor to assure proper tracking and trending are being utilized. The director of nursing or designee, could conduct random audits of the tracking and trending to	21390		

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21390	Continued From page 8 varify the process continues. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	21390		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and functional environment for 8 of 30 residents (R248, R252, R259, R14, R249, R257, R260, R246) whose rooms were observed, and found to have stained carpeting or non-cleanable objects (yarn, plastic garbage bags, and gloves) tied to the over-bed lighting pull-chains. Findings include: During observation and interview on 10/30/17, at 5:12 p.m. R248's room was observed. A light was attached to the wall over the head of R248's bed. There was a short metal pull-chain to turn the light on and off, with non-cleanable items tied to the metal pull-chain. Tied to the pull-chain was a clear plastic garbage bag, then tied to that was a red piece of string. R248 said the pull cord attached to the light broke the previous day, and	21685	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	12/12/17

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	27996	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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21685	Continued From page 9	21685		

after bringing the issue up with staff, was told that maintenance was not in the building on Sunday, and would not be able to fix it until Monday. R248 said the red string and garbage bag made it so the resident could reach to turn the light on and off independently, until fixed. R248 was unsure whether staff told maintenance about the broken cord.

During observation and interview on 10/30/17, at 6:36 p.m. R252's the light was attached to the wall over the head of the bed. had a short, roughly four inch, metal pull-chain to turn the light on and off. There was a cord attached to this metal pull-chain, and then a plastic garbage bag tied to the cord. R252 said the garbage bag added length which allowed R252 to tuck under the pillow so the resident could reach to turn the light on independently. R252 said the garbage bag was already tied to the cord and pull-chain upon admission.

On 10/31/17, at 8:40 a.m. the light above R259's bed had a pair of disposable gloves tied to the cord that turned the light on and off. In a follow up interview that day, at 11:29 a.m. R259 said the the gloves tied to the cord had "been a life saver," and explained tucking the gloves under a pillow in bed so R259 could operate the light independently. R259 said the gloves were already tied to the cord when R259 admitted to the facility.

During observation on 10/30/17, at 4:59 p.m. the light over R14's bed had plastic garbage bags tied to the light's pull-chain, and attached to the bed rail.

On 10/31/17, at 9:31 a.m. plastic garbage bags were observed tied to the pull-chain connected to

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21685	Continued From page 10 the light over the bed in R249's room. Additionally, the carpeting was observed to be stained with multiple dark gray/brown areas. R249 verified the carpet stains were present at the time of admission. During observation of the room shared by R257 and R260 on 10/31/17, at 9:48 a.m. plastic garbage bags were tied to the pull-chain that attached to the light over the bed. Additionally, the carpeting had multiple light brown spots next to the bed and chair. During a follow-up interview on 11/1/17, at 2:27 p.m. R257 said the carpet stains were present at the time of admission. During observation on 10/31/17, at 10:23 a.m. the carpet just outside the doorway of R246's room had a large pattern of dark stains. During a tour of the environment on 11/1/17, starting at 2:19 p.m., the director of environmental services (DES) observed the black stains outside of R246's room, and confirmed that these stains were permanent, as environmental staff had cleaned as much as possible to try and remove the stain. The DES said this stain would remain until that section of carpet was replaced. Continuing on the tour, the DES observed the soiled carpeting in the room shared by R257 and R260, and said it was possible the stains were from coffee. At this time, R257 clarified that neither R257 or R260 were coffee drinkers. The DES said that carpets were to be shampooed after each resident discharge, and explained that coffee stains should come out of the carpet during a shampoo, but might set in if not acted upon promptly. In addition to shampoo post discharge, the DES said carpets were to be cleaned twice monthly.	21685		

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21685	Continued From page 11 The DES observed garbage bags and gloves tied to the pull-chains on the lights over the heads of resident beds. The DES explained that any white cords tied to the short metal pull-chain was a cleanable cord, similar to the cords attached to bathroom call lights, and were able to be cleaned with the disinfectant soaked rags used by housekeeping. The DES confirmed that plastic garbage bags and disposable gloves should not be used to elongate the pull-cord, but that environmental services should be able to find longer metal pull-chains, or longer cleanable cords that the residents can reach, and that can be cleaned appropriately. After residents mentioned the garbage bags and disposable gloves had been there since admission, the DES wondered if it was possible that the plastic garbage bags and disposable gloves could have been in place from prior residents. Review of the Cleaning Guidelines policy, last revised 8/17/12, revealed the facility policy to "provide and maintain a safe, functional, sanitary and comfortable environment for residents, staff members and the public." Step 2, Carpeted Surfaces, established that carpets would be cleaned as needed. Step 4, Terminal Cleaning, required the unit to be stripped upon resident discharge, and cleaned and disinfected before used by the new resident. SUGGESTED METHOD OF CORRECTION: The maintenance supervisor, administrator or designee could review and revise policies and procedures related to ensuring overhead bed lights have proper cording and the carpeting is cleaned when soiled. The maintenance	21685		

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21685	Continued From page 12 supervisor, administrator or designee could develop a system to educate staff and develop a monitoring system to ensure overbed light cords and carpeting is maintained in a clean and sanitary process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure documents with resident diagnoses were confidential. This had the potential to impact 4 of 4 residents	21860	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	12/12/17

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21860	Continued From page 13 reviewed for privacy (R261, R256, R265 and R246). Findings include: On 10/30/17, at 4:39 p.m. a brief tour of the unit was completed with the nurse manager (RN)-C and signs were observed outside the rooms of R256, R246, R261 and R265. Document review revealed each sign said, "Visitors! Please report to the nurses's station before entering room. STOP Flip to Back for Instructions. On the back of each sign were precautions related to entering each resident's room such as use of gloves, masks, gowns and hand hygiene. The back of the sign also included the diagnosis listed for the resident. Immediately following the tour, RN-C and the infection control nurse (RN)-H confirmed the staff were putting the diagnosis on the back of the sign. RN-C and RN-H explained while it would be necessary for all staff and visitors to know proper infection control precautions, it would not be necessary for all staff and visitors to know the resident's diagnosis. RN-C reported she would ensure the signs were changed to remove the diagnosis from each sign. On 10/30/17, at 4:30 p.m., R261 reported no concern related to the diagnosis on the sign outside the door. On 10/30/17 at 6:42 p.m., R256 reported no concerns related to privacy. On 11/2/17 at 9:36 a.m., R265 reported no concern related to the diagnosis on the sign outside the door. On 11/2/17 at 2:42 p.m., R246 reported no	21860		

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21860	Continued From page 14 concern related to the diagnosis on the sign outside the door. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure confidential information is not posted. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21860		